## X-ray Technicians – Second survey

## X-ray and other radiation exposures (personal history)

- 28. Please indicate how frequently you had any of the following DIAGNOSTIC PROCEDURES during the specified calendar years. If you never had a particular procedure, mark the box for "Never had" and leave all other columns blank for that procedure. Please count the number of times you had a procedure, NOT the number of individual films taken.
  - O I have not had any of the procedures listed below (GO TO QUESTION 29)

PROCEDURES	NEVER	Before 1980 NUMBER TIMES				1980-1989 NUMBER TIMES				1990 or later NUMBER TIMES			
PERFORMED ON YOU	HAD	0	1	2-4	5+	0	1	2-4	5+	0	1	2-4	5+
Upper gastrointestinal (GI) series Barium swallow Barium enema	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _
Cholecystogram or cholangiogram Retrograde or intravenous pyelogram Renal arteriogram	_   _   _		_   _   _	_   _   _	_   _   _		_   _   _	_   _   _	_   _   _				
Urethrogram or cystogram Multi-film procedure, other than above Angiogram, other than above	_   _   _   _		_   _   _	_   _   _	_   _   _		_   _   _	_   _   _	_   _   _				
Fluoroscopic procedure, other than above CAT or CT scan MRI procedure	- -  - -  - -	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	          -	_   _   _	_   _   _	_   _   _
Skull x-ray Cervical spine x-ray Sinus x-ray	_   _   _		_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _			
Head/neck x-ray, other than above Collarbone x-ray Shoulder x-ray	_   _   _   _		_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _				
Rib x-ray Thoracic spine x-ray Lumbar spine x-ray	_   _   _		_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _				
Lumbosacral spine x-ray Abdomen x-ray Kidney/ureter/bladder x-ray	_   _   _		_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _	_   _   _				
Pelvis x-ray Extremities (arms, legs) x-ray Mammography x-ray	_   _   _						_   _   _	_   _   _	_   _   _				

29. Please indicate how frequently you had DENTAL OR CHEST X-RAYS during the specified calendar years. If you never had a particular procedure, mark the square for "Never had" and leave all other columns blank for that procedure. Please count the number of times you had a procedure, NOT the number of individual films taken.

PROCEDURES PERFORMED ON YOU	NEVER HAD		BEFORE 1980 NUMBER TIMES			1980-1989 NUMBER TIMES				1990 OR LATER NUMBER TIMES			
		0	1-9	10-24	25+	0	1-9	10-24	25+	0	1-9	10-24	25+
Dental x-ray	0	О	О	О	О	О	О	0	О	О	О	0	О
Chest x-ray	О	О	O	O	O	О	O	O	O	О	O	O	O

- 30. As a PATIENT, have you undergone any RADIOTHERAPY procedures, including radium implants or other brachytherapy? Here, we are interested in procedures performed ON YOU, not those performed BY YOU.
  - O No (GO TO QUESTION 31)
  - O Yes ® Please indicate whether you <u>received</u> radiotherapy to any of the following body areas for cancer or any other condition during the specified calendar years. If you did not receive radiotherapy during a specific time period, leave items under that column blank. If you never received radiotherapy to a particular body area, mark the square for "Never received" and leave all other columns blank for that body area.

BODY AREA	Never	Before	e 1980	1980	- 1989	1990+		
TREATED WITH RADIOTHERAPY	received	For Cancer	Not for Cancer	For Cancer	Not for Cancer	For Cancer	Not for Cancer	
Head or neck	О	О	O	O	O	О	О	
Shoulder	О	О	О	O	О	О	О	
Chest or spine	О	О	О	0	О	О	О	
Abdomen	О	О	О	0	О	О	О	
Pelvis	О	О	0	0	О	О	0	
Extremities	О	О	О	0	О	О	О	
Other, specify:	О	О	О	О	О	О	О	

- 31. As a PATIENT, have you undergone any NUCLEAR MEDICINE procedures? Here, we are interested in procedures performed ON YOU, not those performed BY YOU.
  - O No (GO TO THE NEXT SECTION)
  - O Yes ® Please indicate whether you <u>received</u> any of the following radionuclides for a diagnostic or therapeutic reason during the specified calendar years. If you did not receive radionuclides during a specific time period, leave items under that column blank. If you never received a particular radionuclide, mark the square for "Never received" and leave all other columns blank for that radionuclide.

TYPE OF	Mover	Befor	e 1980	1980	- 1989	1990+		
TYPE OF RADIONUCLIDE	Never received	For Diagnosi	For s Therapy	For Diagnosi	For s Therapy	For Diagnosi	For s Therapy	
<sup>131</sup> lodine	О	О	О	О	0	0	0	
<sup>125</sup> lodine	0	0	О	О	О	0	О	
<sup>99m</sup> Technecium	0	0	О	0	О	О	О	
<sup>201</sup> Thallium	О	О	О	О	О	0	О	
Other, specify:	О	О	О	О	О	О	О	
Type unknown	О	О	О	О	О	О	О	